

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10W

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02673

2685

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Calvert CITY (If outside corporate limits, write RURAL, OR and give nearest town) TOWN Willows		MARYLAND LENGTH OF STAY (in this place) 8 years	
STATE Maryland CITY (If outside corporate limits, write RURAL, and give nearest town) TOWN Willows		COUNTY Calvert STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) Rosanna		4. DATE (Month) OF DEATH March 14 (Year) 1956	
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH April 1, 1872
9. AGE last birthday 83 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? ✓	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Dublin, Ireland		12. MOTHER'S MAIDEN NAME Mary Connolly	
13. FATHER'S NAME Dennis McGuire		14. MOTHER'S MAIDEN NAME Mary Connolly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS P. Thomas Carton, North Beach, Md. Box 217	
18. MEDICAL CERTIFICATION <i>Hypertensive C.V.R disease</i>			
IMMEDIATE CAUSE (A)			
ANTECEDENT CAUSE(S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, DUE TO (C) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ..... 19 ..... to ..... 19 ..... 19 ..... that I last saw the deceased alive on ..... 19 ..... and that death occurred at ..... A.M. from the causes and on the date stated above. SIGNATURE <i>W. Weems</i> ADDRESS (Street, city, town, state) <i>Huntingtown</i> DATE SIGNED <i>3/14/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Mar. 16 1956	NAME OF CEMETERY OR CREMATORIAL Mt. Harmony
24. REC'D BY REGISTRAR DATE Mar. 15, 1956		REGISTRAR'S SIGNATURE <i>Grace L. Hutchins</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Mr. D. Hutchins Owings, Md.</i>

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02674

2686

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
CITY OR TOWN		Calvert	MARYLAND		STATE Maryland COUNTY Calvert
CITY (If outside corporate limits, write RURAL OR give nearest town)			LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN		Owings	Life		OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) (Day) (Year)		
MARTIN LUTHER CATTERTON			OF DEATH Mar. 17 1956		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months Days Hours Min.
Male	white	Married	July 23, 1910	45 yrs.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Carpenter			Maryland		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Oden Catterton			Georgianna Cox		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		
- - - - -			218-12-9016		
17. INFORMANT & ADDRESS			Mr. George Catterton, Owings, Md.		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
1598 IMMEDIATE CAUSE (A) <i>Carcinoma of g. tract exact</i> ANTECEDENT CAUSE(S) DUE TO <i>location of origin undetermined</i> DISEASES OR CONDITIONS, IF ANY, (B) <i>Aug 1953</i> GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION <i>Feverishable Lupus Erythematosus</i>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug. 1953</i> to <i>March 17, 1956</i> , that I last saw the deceased alive on <i>March 17, 1956</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. SIGNATURE <i>George C. Deth</i> M. D. ADDRESS (Street, city, town, state) <i>1110 E. Frederick</i> DATE SIGNED <i>3/18/56</i>					
23. BURIAL/CREMATION REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county)	
Burial		3/20/56		Mt Harmony, 7th Owings Md (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
DATE 3/19/56		Grace L. Hutchins		J. C. Hutchins (Signature)	

21-10000-10000-10000-10000-10000-10000-10000-10000-10000

CERTIFICATE OF DEATH

FEDERAL BUREAU OF INVESTIGATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24-hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

VS. A1SME(5)  
5M 9/55

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**2687 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02675  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bartow</i>		c. LENGTH OF STAY IN 1b <i></i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bartow</i>		e. STREET ADDRESS <i></i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Larry</i>		First <i>L</i>	Middle <i>Cole</i>
4. DATE OF DEATH <i>3/31/56</i>		Month <i>3</i>	Day <i>21</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>3/31/56</i>		9. AGE (in years last birthday) yrs. <i>17</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i></i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Food</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i></i>	
13. FATHER'S NAME <i>Frederick Cole</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Harris</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Margaret Harris</i>		Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition</i>		INTERVAL BETWEEN ONSET AND DEATH <i></i>	
DUE TO <i>772.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Poor Case</i>			
DUE TO <i>Was admitted in H. Discharged in good cond</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Unmarried parents with no care</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <i></i>		20f. (City or town) <i></i>	
(County) <i></i>		(State) <i></i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i></i>		DATE SIGNED <i>3/22</i>	
22a. BURIAL OR CREMATION, REMOVAL (Specify) <i>3-23, 56</i>		22b. DATE THEREOF <i></i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Carrolls</i>		22d. LOCATION (City, town, or county) <i>Bartow</i>	
(State) <i>Md</i>		(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell. Ph. Fred. Md.</i>		ADDRESS <i></i>	
24a. REC'D BY REGISTRAR <i></i>		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	
DATE <i>2-23-56</i>			

BUREAU Y. S.

MAR 27 1956

RECEIVED

1350234

1 1 2-33125 CARRIERS  
H. E. DERRIDA. M. G. H. D. 39

## INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02676

## 2688 CERTIFICATE OF DEATH

Reg. Dist. No. 52

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
CITY <b>Calvert</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Calvert</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Prince Frederick</b>		LENGTH OF STAY (In this place) <b>7 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Huntingtown</b>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Calvert County Hospital</b>				STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (First) <b>CORA</b> (Middle) <b>WILSON</b> (Last) <b>CRAFORD</b>				<b>4. DATE OF DEATH</b> <b>March 5</b> 1956			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>November 11, 1864</b>	9. AGE last birthday <b>91</b> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>same</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>David I. Bowen</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Ireland</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT & ADDRESS <b>Mrs. Julius O. Bowen, Huntingtown, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>							
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>420.1 IMMEDIATE CAUSE (A) <b>Coronary occlusion</b></p> <p>ANTECEDENT CAUSE(S) DUE TO <b>generalized arterio-sclerosis</b></p> <p>DISEASES OR CONDITIONS, IF ANY, (B) <b>-----</b></p> <p>GIVING RISE TO THE ABOVE CAUSE DUE TO <b>-----</b></p> <p>STATING UNDERLYING CAUSE LAST. (C) <b>-----</b></p>							
INTERVAL BETWEEN ONSET AND DEATH							
<b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) <b>5th Street</b>		(County) <b>Huntingtown</b>	(State) <b>Md.</b>
21d. TIME OF INJURY (Month) <b>March</b> (Day) <b>5</b> (Year) <b>1956</b> (Hour) <b>10</b>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>fall</b>			
<b>22. I hereby certify that I attended the deceased from <b>Mar. 5, 1956</b>, to <b>Mar. 5, 1956</b>, that I last saw the deceased alive on <b>Mar. 5, 1956</b>, and that death occurred at <b>5p.m.</b> from the causes and on the date stated above.</b>							
SIGNATURE <b>Edw. Williams</b> M. D. ADDRESS (Street, city, town, state) <b>5th Street</b> DATE SIGNED <b>3/6/56</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>March 7, 1956</b>		NAME OF CEMETERY OR CREMATORIAL <b>Huntingtown Cemetery</b>		LOCATION (City, town, or county) <b>Huntingtown, Md.</b>	
24. REC'D BY REGISTRAR DATE <b>Mar. 6, 1956</b>		REGISTRAR'S SIGNATURE <b>Grace L. Hutchins</b>		25. MEDICAL DIRECTOR'S SIGNATURE <b>W. H. Hutchins</b>		ADDRESS <b>Owings, Maryland</b>	

STATE CERTIFICATE OF DEATH

RECEIVED

BUREAU Y.

MAR 12 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2689

## CERTIFICATE OF DEATH

02677

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		b. COUNTY <i>Anne Arundel</i>	
c. LENGTH OF STAY IN 1b <i>44 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deale</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>		d. STREET ADDRESS <i>Deale</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Oden</i>	Middle <i>W.</i>	Last <i>Elliott</i>
4. DATE OF DEATH <i>3 19 1956</i>	Month <i>3</i>	Day <i>19</i>	Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/22/1894</i>
9. AGE (In years last birthday) <i>61 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>Joseph Elliott</i>	14. MOTHER'S MAIDEN NAME <i>Martha Jenkins</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>196x</i>	16. SOCIAL SECURITY NO. <i>123-45-6789</i>	17. INFORMANT <i>Mrs. Bessie Elliott</i>	Address <i>Deale, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>196x</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i>	
Conditions, if any, which gave rise to immediate cause (a), slating the under- lying cause last. (b) DUE TO <i>Tumour of spine</i>		3 yrs	
(c) DUE TO <i>Chronic glaucoma</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Has been bedridden for several years</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>31/10/56</i>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>31/10/56</i> , 19 <i>56</i> , to <i>31/10/56</i> , 19 <i>56</i> , that I lost sow the deceased alive on <i>31/10/56</i> , 19 <i>56</i> , and that death occurred at <i>Deale</i> , 19 <i>56</i> , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Deale, Md.</i>	DATE SIGNED <i>3/11/56</i>		
ACTUAL SIGNATURE <i>Howard</i>	M.D.		
PHYSICIAN'S NAME (Type)	<i>Deale, Md.</i>		
22a. BURIAL, CREMATION REMOVAL, (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/20/56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Woodfields</i>	22d. LOCATION (City, town, or county) <i>Deale, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard O. Hardy, Dealeville</i>	ADDRESS <i>Dealeville, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>3/23/1956</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. Hugh Hardy</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4

may be retained by the hospital, attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be retained by the funeral director.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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U. S. DEPARTMENT OF JUSTICE

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U. S. DEPARTMENT OF JUSTICE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2690. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02679

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
<i>Calvert</i>		a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
<i>Solomons</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
<i>Calvert Co</i>		<i>GROVER</i>	
3. NAME OF DECEASED (Type or print)		First <i>Robert</i>	Middle <i>William</i>
		Lost <i>Robert</i>	4. DATE OF DEATH
			Month <i>3</i> Day <i>9</i> Year <i>1956</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
<i>M</i>		<i>W</i>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sept. 12 1945
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Robert</i>		<i>—</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Md</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Robert</i>		<i>Thelma McCready</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
<i>—</i>		17. INFORMANT	
		<i>Verley McCready</i>	
		Address <i>Fusby, Calvert Co., Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<i>Crossed chest with hammer</i>			
DUE TO			
<i>Auto accident</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b),			
DUE TO			
<i>—</i>			
DUE TO			
<i>—</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<i>Was hit when he was going down</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>4:00 p.m. 3/9 1956</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <i>at road</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) <i>Solomons</i> (County) <i>Calvert</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
SIGNATURE <i>H. W. Ward</i>		DATE SIGNED <i>3/9/56</i>	
EXAMINER'S NAME (Type) <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar. 12, 1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Paul's Cemetery</i>		22d. LOCATION (City, town, or county) <i>Fusby - Calvert Co - Md.</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>O. A. Harkness &amp; Son - Mutual, Md.</i>		ADDRESS	
		24a. REC'D BY REGISTRAR DATE <i>3-12-56</i>	
		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	

COVINGTON V. 4

MAR 12 1968

125-1165

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "Word 'pending'" in pencil in Item 18. Give Bag 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02680

**2691 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 57

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Island Creek</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Island Creek</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William</i>		First <i>James</i>	Middle <i>Sam</i>
4. DATE OF DEATH Month <i>Jan</i> Day <i>3</i> Year <i>1956</i>		5. SEX <i>M</i>	
6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>1870</i>		9. AGE (in years to birthday) <i>76</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Sam</i>		14. MOTHER'S MAIDEN NAME <i>Matte Sam</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>Ward</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary embolism</i>	
DUE TO <i>Has been ailing for sometime 2 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 month</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Arteriosclerosis</i>		(b) <i>Has been ailing for sometime 2 yrs</i>	
DUE TO <i>Arteriosclerosis</i>		(c) <i>Arteriosclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASIDE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <i>Yes</i> <input type="checkbox"/> <i>No</i> <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <i>Was feeling good got up dressed. Collapsed at 5:30 AM at 10 AM</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Island Creek</i> (County) <i>Md</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H Ward</i>		DATE SIGNED <i>3/27/56</i>	
22a. BURIAL OR CREMATION, REMOVAL (Specify) <i>4-1-56</i>		22b. DATE THEREOF <i>4-1-56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Brooke</i>		22d. LOCATION (City, town, or county) <i>Island Creek Md</i> (State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>R E Sewell Fred, Md</i>		24a. REC'D BY REGISTRAR DATE <i>3-28-56</i>	
		24b. REGISTRAR'S SIGNATURE H. A. Ward	



## 2692 CERTIFICATE OF DEATH

Reg. Dist. No. 51

<b>1. PLACE OF DEATH</b> COUNTY <i>Calvert</i> MARYLAND CITY (If outside corporate limits, write RURAL OR end give nearest town) LENGTH OF STAY (in this place) TOWN <i>Prince Frederick</i> 15 min.				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <i>Maryland</i> COUNTY <i>Calvert</i> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Chesapeake Beach, Md.</i> STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (First) <i>Bell</i> (Middle) <i>Hubbard</i> (Last) (Type or Print)				<b>4. DATE OF DEATH</b> 3 7 1956			
S. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	B. DATE OF BIRTH <i>3/31/1888</i>	9. AGE last birthday <i>67</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Samuel Somers</i>				14. MOTHER'S MAIDEN NAME <i>Ana Moore</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <input type="checkbox"/> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT & ADDRESS <i>Mr. Collier Hubbard Chesapeake Beach, Md.</i>			
<b>18. MEDICAL CERTIFICATION</b> I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <i>Atrial Fibrillation</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH <i>the day.</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) <i>Huntingtown, Md.</i> (State) <i>St. Marys Co.</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>M.</i>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>10 Feb.</i> 19 <i>53</i> , to <i>7 Mar.</i> 19 <i>56</i> , that I last saw the deceased alive on <i>7 Mar.</i> 19 <i>56</i> , and that death occurred at <i>9 1/2 M.</i> from the causes and on the date stated above. SIGNATURE <i>H. W. Ward</i> ADDRESS (Street, city, town, state) <i>Huntingtown, Md.</i> DATE SIGNED <i>7 Mar. 56</i> VS AFSC 155-10M							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Mar. 10</i>		NAME OF CEMETERY OR CREMATORIUM <i>Cofford Rd.</i>		LOCATION (City, town, or county) (State) <i>Cofford Rd.</i>	
24. REC'D BY REGISTRAR <i>Bell</i>		REGISTRAR'S SIGNATURE <i>H. W. Ward</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice E. Newberry</i>		ADDRESS <i>109</i>	
DATE <i>3-7-56</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02682

2693

## CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bowens</i>		c. LENGTH OF STAY IN 1b <i>76 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bowens</i>		d. STREET ADDRESS <i>Bowens</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bowens</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Etta Victoria Hutchins</i>		First <i>Etta</i>	Middle <i>Victoria</i>	Last <i>Hutchins</i>	4. DATE OF DEATH Month <i>March</i>	Month <i>24</i>	Day <i>1956</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>27 Apr 11, 1880</i>	9. AGE (In years last birthday) <i>75 yrs</i>	10. IF UNDER 1 YEAR Months <i>11</i>	11. IF UNDER 24 HRS Days <i>11</i>	12. IF UNDER 24 HRS Hours <i>11</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Bowens</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Thomas W. Hall</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Hutchins</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>John W. Hutchins</i>		Address <i>Bowens, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last. <i>Hyper-tension</i>		Heart Failure - Coronary Thrombosis				INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
(b) DUE TO <i>Hyper-tension</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cardio-Vascular Disease</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7315 Landover Rd. Hyattsville, Md.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>27 March 1955</i> to <i>15 March 1956</i> , that I last saw the deceased alive on <i>15 March 1956</i> , and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>7315 Landover Rd. Hyattsville, Md.</i>		DATE SIGNED <i>3/26/56</i>	
ACTUAL SIGNATURE <i>Thomas W. Hutchins</i>							
PHYSICIAN'S NAME (Type) <i>THOMAS W. HUTCHINS</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar. 27, 1956</i>		22c. NAME OF CEMETERY OR CEMATORIAL <i>Asbury Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Barstow - Calvert Co. - Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Hackness &amp; Son - Mutual, Md.</i>		ADDRESS <i>A. A. Hackness &amp; Son - Mutual, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>3-26-56</i>		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	

24.60

17.7

17.7

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2694

## CERTIFICATE OF DEATH

038250  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cabret MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cabret	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick 3 days		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cabret County Hospital		e. STREET ADDRESS Solomons	
3. NAME OF DECEASED (Type or print) Joseph		4. DATE OF DEATH	Month March Day 26 Year 1956
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1873 9. AGE (in years lost birthday) 82 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) Cabret County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Selby		14. MOTHER'S MAIDEN NAME Matilda Cullemier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-01-1081 17. INFORMANT W. Edward Selby - Solomons, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 152x DUE TO Inanition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinoma Ileum - (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 25, 1956, to Mar. 28, 1956, that I last saw the deceased alive on Mar. 25, 1956, and that death occurred at 10A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE E. S. COSTER		ADDRESS (Street, city or town, state) Solomons, Md. DATE SIGNED 3/28/56	
PHYSICIAN'S NAME (Type) E. S. COSTER		SOLOMONS, MD.	
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF Mar. 28, 1956	
22c. NAME OF CEMETERY OR CREMATORIUM Solomons Methodist		22d. LOCATION (City, town, or county) Solomons, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE A. A. Harkness & Son - Mutual, Md.		24a. REC'D BY REGISTRAR DATE 3/28/56	
		24b. REGISTRAR'S SIGNATURE E. S. COSTER	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1800

1800

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02683

Reg. Dist. No. 32

Item 9, Filed 3-19-56

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sunderland</i>		b. COUNTY <i>Calvert</i>	
c. LENGTH OF STAY IN 1b <i>1 week</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sunderland</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i></i>		d. STREET ADDRESS <i></i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Wm C. Straaten</i>		First <i>Wm</i>	Middle <i>C.</i>
4. DATE OF DEATH Last <i>Oct. 1</i>		Month <i>Oct.</i>	Day Year <i>16 1956</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 1, 1865</i>
9. AGE (In years last birthday) <i>91 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welder</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>James Straaten</i>	14. MOTHER'S MAIDEN NAME <i>Emma Jones</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Virginia Gray Sunderland</i>	Address <i>1012 W. 36th St., Baltimore, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary embolism</i>		INTERVAL BETWEEN ONSET AND DEATH <i></i>	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>			
DUE TO  (b) <i></i>			
DUE TO  (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year <i>1142 a.m. 3/16 1956</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. Ward, D.M.E.</i>		DATE SIGNED <i>3/16/56</i>	
22a. BURIAL OR CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-19-56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Brooks</i>
22d. LOCATION (City, town, or county) <i>Island Creek</i>		(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. W. Ward</i>		24a. REC'D BY REGISTRAR DATE <i>3-19-56</i>	24b. REGISTRAR'S SIGNATURE H. W. Ward

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02678

## 2696 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Maryland and Barstow, Md. (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS		
3. NAME OF DECEASED (Type or Print)	(First) Edward	(Middle) Joyce	4. DATE (Month) (Day) (Year) OF DEATH 3 - 31 - 1956
5. SEX m	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John Joyce	14. MOTHER'S MAIDEN NAME Harriet White		12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Thornton Joyce Prince Fred
8. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A)		18. MEDICAL CERTIFICATION	
ANTECEDENT CAUSE(S) DUE TO		Coronary Thrombosis -	
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		Secondary Sclerosis	
DUE TO (C)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 57 1956 31 10 31 1956			
22. I hereby certify that I attended the deceased from 3/3/57 alive on March 31, 1956, and that death occurred at 10 A.M., from the causes and on the date stated above. SIGNATURE R. Williams M.D. ADDRESS (Street, city, town, state) St. Thomas 4/2 DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF 4-3-56	NAME OF CEMETERY OR CREMATORIAL Carrolle
24. REC'D BY REGISTRAR DATE 4/3/56		REGISTRAR'S SIGNATURE H. W. Ward	LOCATION (City, town, or county) (State) Barstow, Md.
25. FUNERAL DIRECTOR'S SIGNATURE P. E. Scull Jr. Fred, Md.		ADDRESS	

RECEIVED  
APR 4 1956

SULLIVAN M. S.

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 2697 CERTIFICATE OF DEATH

02684

Reg. Dist. No. 52

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY	Calvert	MARYLAND	STATE	Maryland	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN Sunderland		Life	TOWN Sunderland		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		
3. NAME OF DECEASED (Type or Print)			(First) WILLIAM	(Middle) SAMUEL	(Last) TURNER
4. DATE OF DEATH			Month March	Day 15	Year 1956
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR
Male	white	Married	January 26, 1887	69 yrs.	Months Days Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	
Farming			Owner	Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Samuel Turner			Ida Virginia Marquess		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
(If Yes, give war or dates of service)		217-36-7322		Mrs. Wm. Turner, Sunderland, Md.	
18. MEDICAL CERTIFICATION					
<p><b>I</b> DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH          420.1 IMMEDIATE CAUSE (A) <u>CORONARY Occlusion</u>          ANTECEDENT CAUSE(S) DUE TO          DISEASES OR CONDITIONS, IF ANY, (B) <u>Gastric ulcer</u>          GIVING RISE TO THE ABOVE CAUSE DUE TO          STATING UNDERLYING CAUSE LAST. (C) <u>Varicose veins of both legs</u>  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING          TO THE DEATH BUT NOT RELATED TO THE          DISEASE OR CONDITION CAUSING DEATH.</p>					
INTERVAL BETWEEN ONSET AND DEATH <u>28 hours</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<p><b>22. I hereby certify</b> that I attended the deceased from <u>Sept 1955</u> to <u>March 15, 1956</u>, that I last saw the deceased  <u>alive on March 15, 1956</u>, and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.</p> <p>SIGNATURE <u>Jacob J. H.</u> ADDRESS (Street, city, town, state) <u>Burke Frederick 3/16/57</u> DATE SIGNED <u>3/16/57</u></p>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county) (State)
Burial		Mar. 17 / 56	Mt. Harmony Cemetery		Owings, Maryland
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
DATE 3/17/56		Grace L. Nutkins		H. H. Stulikins (Signature)	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02685

2698

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Solomons</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Solomons</i>	
d. STREET ADDRESS <i>—</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Sarah</i>	Middle <i>Elizabeth</i>	Last <i>Webster</i>
4. DATE OF DEATH	Month <i>May</i>	Day <i>11</i>	Year <i>1956</i>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 26, 1873</i>
9. AGE (In years last birthday) <i>82 yrs.</i>	10. IF UNDER 1 YEAR Months <i>9</i>	11. IF UNDER 24 HRS. Days <i>15</i>	12. Hours <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John J. Saunders</i>		14. MOTHER'S MAIDEN NAME <i>Sarah E. Vaughan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>H. B. Glascott - Solomons, Md.</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>Cerebral Vascular Accident</i> <i>Arteriosclerotic C.V. disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i> <i>5 years</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June</i> , 1955, to <i>May 11, 1956</i> , that I last saw the deceased alive on <i>Feb 20, 1956</i> , and that death occurred at <i>3 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>—</i>			
ACTUAL SIGNATURE <i>Sarah Jett</i>		DATE SIGNED <i>—</i>	
PHYSICIAN'S NAME (Type) <i>PAUL C. SETT</i>		PRINCE FREDERICK, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar. 13, 1956</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Middleham Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>Fusby - Calvert Co - Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>O. A. Haskins &amp; Son - Mutual, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>3-18-56</i>	
ADDRESS <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed with 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE - GOVERNMENT OF MEXICO - GUADALAJARA - 1950

CERTIFICATE OF AUTHORITY

S-102

BUREAU V. S.

MAR 14 1950

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